

McLaren Print System Order

Order No: 77625
 Order Date: 2023-06-01
 User: Jennifer Dixon
 Phone: 810.342.2138

Ship Location: Jeni Dixon/McLaren Imaging Center
 501 S Ballenger Hwy, Suite B
 Flint, MI 48532

Forms
 Quantity: 50
 Paragon Dept No: 32011
 Dept Name: McLaren Imaging Center
 Company Number: 60

Order Total Price: 655.00

Item Number: M-22016-B
 Item Description: Imaging Center Order Form
 Revision Date: 7/2021
 Print:
 Paper:
 Size:
 Fold:
 Finish:
 Drill:
 Poster:
 Misc Info: ds; full color; 50 Sheets per pad. Please order how many pads you would like. BW

McLaren FLINT		OUTPATIENT RADIOLOGY ORDER FORM		Appointment Date _____
				Appointment Time _____
10000 WOODLY BLDG McLaren Imaging Center • Ph: 810.342.4800 Fax: 810.342.4830 McLaren MRI Ballenger Hwy • Ph: 810.225.3071 Fax: 810.225.3076 McLaren Flintout Imaging Services • Ph: 810.426.2000 Fax: 810.426.2040				
Patient Name _____ DOB _____ Height _____ Weight _____		INSTITUTION PHONE _____		
INSURANCE _____		PRI AUTHORIZATION NUMBER _____		
DIAGNOSIS/REASON FOR EXAM (PLEASE INCLUDE LATERALITY, SPECIFIC SITE) _____				
ORDERING PROVIDER (PRINT NAME) _____		OFFICE CONTACT _____		
MRI	<input type="checkbox"/> MRI <input type="checkbox"/> MRIA <input type="checkbox"/> MRV	<input type="checkbox"/> MRI HEART W/O <input type="checkbox"/> MRI HEART W/I <input type="checkbox"/> MRI HEART VELOCITY FLOW MAP	<input type="checkbox"/> CTX HEART W/O <input type="checkbox"/> CTX HEART CALCIUM SCORING	
X-RAY	<input type="checkbox"/> X-RAY <input type="checkbox"/> FLUOROSCOPY <input type="checkbox"/> DIGITAL SUBTRACTION	<input type="checkbox"/> SKULL <input type="checkbox"/> CERVICAL <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PELVIS	<input type="checkbox"/> LUNG <input type="checkbox"/> SPINE <input type="checkbox"/> JOINTS <input type="checkbox"/> EXTREMITY <input type="checkbox"/> OTHER	<input type="checkbox"/> SE <input type="checkbox"/> CT/TOGROGRAM - See Back of Order for Page
US	<input type="checkbox"/> PELVIC (WITH TRANS VAG IF NECESSARY) <input type="checkbox"/> ABDOMEN <input type="checkbox"/> PROSTATE <input type="checkbox"/> COLOR DOPPLER <input type="checkbox"/> EXTREMITY <input type="checkbox"/> OTHER	<input type="checkbox"/> TESTICLE (WITH COLOR FLOW IF NECESSARY) <input type="checkbox"/> BLADDER <input type="checkbox"/> TONGUE <input type="checkbox"/> DUCTS <input type="checkbox"/> OTHER	<input type="checkbox"/> RENAL KIDNEY <input type="checkbox"/> RENAL ARTERY <input type="checkbox"/> BREAST (DOPPLER) <input type="checkbox"/> BREAST (COLOR FLOW) <input type="checkbox"/> ARTERIAL (COLOR FLOW IF NECESSARY)	
CT	<input type="checkbox"/> HEAD <input type="checkbox"/> NECK <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> OTHER	<input type="checkbox"/> PELVIS <input type="checkbox"/> SPINE <input type="checkbox"/> RENEAL STONE <input type="checkbox"/> UROGRAM	<input type="checkbox"/> CTN <input type="checkbox"/> ABDOMEN <input type="checkbox"/> EXTREMITY <input type="checkbox"/> OTHER	
MOBILE	<input type="checkbox"/> PRONE BONE <input type="checkbox"/> VIO SCANS <input type="checkbox"/> MOBILE SCANS	<input type="checkbox"/> WITH TOTAL BODY IF NECESSARY <input type="checkbox"/> MUGA <input type="checkbox"/> RENAL (WITH LADG) <input type="checkbox"/> OTHER	<input type="checkbox"/> LEUKOCYTE SCANS (BONE MARRROW) <input type="checkbox"/> RENAL (WITHOUT LADG) <input type="checkbox"/> OTHER	
BREAST	<input type="checkbox"/> MAMMOGRAPHY (WITH BI-RADS) <input type="checkbox"/> MAMMOGRAPHY (WITH BI-RADS) <input type="checkbox"/> MAMMOGRAPHY (WITH BI-RADS) <input type="checkbox"/> MAMMOGRAPHY (WITH BI-RADS) <input type="checkbox"/> MAMMOGRAPHY (WITH BI-RADS)			
PROCEDURE	<input type="checkbox"/> CYST ASPIRATION <input type="checkbox"/> BIOPSY <input type="checkbox"/> OTHER	<input type="checkbox"/> SALICITIN <input type="checkbox"/> US-GUIDED <input type="checkbox"/> NEEDLE ASPIR BX	<input type="checkbox"/> LUNG BIOPSY <input type="checkbox"/> HEPATIC BIOPSY <input type="checkbox"/> PANCREATIC BIOPSY	<input type="checkbox"/> ARTHROGRAM
<input type="checkbox"/> TELEPHONE REPORT (Print Patient) _____ <input type="checkbox"/> TELEPHONE REPORT (Release Patient) _____		PROVIDER Signature _____ Date _____ Time _____ Signature stamps are not valid.		
Contract will be added as necessary to optimize the diagnostic capability of the exam. Additional studies will be performed as medically necessary to optimize the diagnostic capability of the study that is being performed (e.g., a scan for an abnormal bone scan). Signing this form indicates your agreement of the above.				

Spec Info: ASAP